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Delegation: perception and practice in community nursing

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The changing demands on primary health care have focused attention on workforce diversification. Although skill mix has been researched for some time, exploration of delegation decision-making is an underresearched topic. This limits the sharing, teaching and monitoring of the inherent skills. Utilizing focus groups, this exploratory research was therefore designed to map delegation perceptions, experiences and decision-making processes of health visitors and districts nurses in a primary care trust in the north of England. The focus group discussions revealed a diversity of delegation practices. Decisions were driven by both pragmatic and needs assessment factors. Issues around the delegatee, the delegator, patient need and structural factors were strongly influential. Delegation of aspects of 'established' care was at times in conflict with the philosophy of holistic care. The research suggests that it is important to recognize the community context of practice increases the complexity of delegation decision-making.

Key words: decision-making; delegation; primary care workforce; workforce diversification

Introduction

Primary care has undergone considerable change in recent years as a result of contemporary UK government policy (Department of Health, 1991; 1997; 1999a; 1999b; 2000b). A movement of care delivery from the hospital into the community setting, shorter hospital stays, an increase in day surgery procedures and an ambitious public health agenda have all increased demands on the workforce. Consequently, teams of health care workers are evolving to meet these changing and developing needs. New roles, such as nurse practitioners and public health nurses, have been introduced. Other roles, such as district nurse and health visitor, have undergone varying levels of development and transformation and the remits of health care assistants and community staff nurses are evolving. Recent government reports

such as the Wanless Report (2001) and the Primary Care Workforce Planning Framework (Department of Health 2002) set the scene for continued diversification to meet health care needs and enhance the quality of health service provision.

Although role development, skill mix, and grade mix in nursing and midwifery has been researched from a variety of dimensions over a period of time, (Coomber *et al.*, 1992; Cowley, 1993; Daykin and Clarke, 2000; Hockey, 1972; Jenkins-Clarke *et al.*, 1998; McIntosh *et al.*, 1999; McKenna and Hasson, 2002), this is still what McIntosh *et al.* (1999: 70) refer to as 'contentious and under researched topic'.

In particular, there is limited knowledge on a key component of skill mix or substitution activity, that of the process of making delegation decisions. This limits sharing, teaching and monitoring of the inherent skills in these processes. This paper reports the findings of a study carried out in the north of England with health visitors (HV) and district nurses (DN) to explore their perceptions of the concept of delegation and their reported delegation practice. It builds

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particularly on the work of McIntosh *et al.* (1999) and indeed endorses some of their findings. This study was extended to include HVs as well as DNs. This provided the opportunity to acknowledge specialism-specific issues, but also allowed for the potential to capture the shared influence of community context of practice.

It is not our intention in this paper to debate the issue of skill mix. The concept and the process have been well addressed elsewhere, for example Cowley (1993), and McKenna (1995). The focus is on the exploration of nurses' experiences of engaging in delegation practices within an actual or potential skill mix environment. We will therefore inevitably address debates about what are appropriate care responsibilities for different types of health care worker, but from the perspective of how this impacts on the delegation process. Specifically, the challenges of delegation decisions in the community context. The paper therefore has two aims:

- 1) A mapping of what these nurses mean when they talk about delegation. Illumination of how the term and concept is interpreted is necessary to develop practice.
- 2) Capturing and making available to others (both within the research sample and beyond) the experiences of nurses in one primary care trust.

The paper initially presents an overview of the drivers and direction of change in primary care that impinge on delegation practices. This is followed by a discussion of research design and methods. The findings of the research are then presented, together with a discussion of how delegation is understood and practised by the research population.

Primary care workforce: drivers and direction of change

The amount and range of care delivered in the primary care setting is increasing. Workforce developments must be responsive to the government modernizing agenda for all public services and to the aim of achieving a 'workforce of all talents' (Department of Health, 2000a). The Wanless report (2001) reviewing health service configurations predicts significant workforce

changes in the next 20 years. The intention is to develop 'better use of a skilled workforce – extending roles and breaking down professional boundaries' (p. 30). A clear movement is foreseen with health care assistants delivering 'a large part of the routine work of nurses' and nurses undertaking work currently delivered by general practitioners.

A number of activities are at play in workforce configurations: role substitution, role expansion, role development. Many of these challenge existing professional domains and have received a variety of receptions. On an educational level, the introduction of 'A New Preparation for Practice' in 1986 (UKCC, 1986) set the potential for a community staff nurse workforce. However, the impact of this has to some extent been hindered by what Forbes *et al.* (2001) refer to as the confusion surrounding the staff nurse role in the community context. A significant driver for the confusion is the fact that the core skills necessary for the role are seen to be different to those required for the hospital setting, but that difference is not well articulated or standardized. McKenna and Hasson (2002) highlight a similar debate in relation to the need for midwifery assistants rather than the generic health care assistants to facilitate skill mix developments in midwifery services in Ireland.

A prominent route to the development of a diversified workforce has been the mapping of nursing skills or tasks performed in the process of patient care. Indeed this was the much criticized approach taken by the government Value for Money Unit who Cowley (1993) accused of placing: '... an unwarranted faith on the simplicity of nursing practice. This seems to have led them to consider only single aspects, whereas a multiplicity of factors need consideration' (p. 166).

In a similar vein, McIntosh *et al.* (1999) suggest that: '...the nursing tasks undertaken cannot be used as proxy indicators of the skills required to give holistic care' (p. 75). The attempts to reduce practice to individual skills may be perceived as a threat to the process model of care which has been developed in nursing over recent years (Hicks and Hennessy, 2000).

Articulating and acknowledging the complexities of care management is therefore integral to any workforce developments. However, the problems highlighted by McKenna and Hasson (2002)

in relation to midwifery could be transferred to other types of care provision: '... it is acknowledged that midwifery skills cover practical tasks but also activities that depend on higher cognitive skills, experience, intuition, instinct, all of which are difficult to quantify' (p. 54).

This research explores some of these issues by exposing and explaining how a group of community nurses perceive and practise delegation.

Research methods

Two factors were particularly significant in the selection of the focus group method for this research (Kitzinger, 1995; Kreuger, 1988; Webb and Kevern, 2001). Firstly the study was exploratory and focus groups allow the research question to be explored and redefined by the participants as the articulation develops and relevant issues are exposed. Second, we wanted interaction between participants so that a variety of experiences and perceptions of delegation could be shared and indeed debated by groups of nurses. This was particularly necessary because of the varied levels of experience in delegation within the community setting and the variety of potential delegatee roles which were developing.

Four focus groups (Nos 5–8) were held, two with HVs (G or H grade) and two with DNs (G and H grade). Two factors were influential in the decision to make the groups unidisciplinary. Firstly, we wished the group members to be familiar, feel confident and safe to explore their experiences and perceptions. Although the sample was drawn from one primary care trust, opening the groups to trust-wide sampling would introduce unfamiliar personnel. Second, although the two professional groups share a context of practice, the delegation options for the two groups were different. Rather than share the diversity of delegation experience between groups, we wished at this stage to develop depth within groups. Intergroup sharing was therefore seen as a potential future option.

The experience levels in the groups ranged from newly qualified to many years of practice. In the DN groups, some of the participants had previously worked as staff nurses in the same teams prior to undertaking the specialist

practitioner programme. This group was therefore able to discuss delegation from both delegator and delegatee perspectives. Most DNs could draw from a team of health care assistants and staff nurses when engaging in delegation. There was considerable diversity in the delegation options available to HVs. Some reported that they had no-one with whom to delegate, others reported having the option of delegating to a nursery nurse or an administrator. Both DNs and HVs could also potentially delegate care to other members of the primary health care team.

All focus groups were conducted in a similar way. They were facilitated by two researchers with whom the majority of staff were familiar. The groups were asked about their perceptions and experiences of delegation and were requested to draw on both successful and unsuccessful examples of delegation from their practice. The groups familiarity with each other, together with their familiarity with the researchers made for free and active discussion of trigger questions which only required limited clarification and prompting. The participants exchanged experiences, questioned how delegation practices were managed by colleagues and shared their visions of how this aspect of care management should and could be developed. All group participants contributed to the discussion and the dynamics appeared to allow equitable opportunities. Overall, there was a high degree of consensus in the group discussions. Any level of disagreement that did occur is highlighted in the discussion of findings.

The focus groups were audiotaped and later transcribed. As is typical with qualitative data, analysis had to be sensitive to content detail, facilitate exploration, development and testing of themes. This was achieved by co-analysis by both researchers using a constant comparative approach managed by NUD*IST software. In order to aid clarity and validity of the findings, quotations from the focus groups are identified by DN or HV, an individual number and a focus group number. This gives some indication of the breadth of participant contribution.

Findings

Practitioner's perceptions of the concept of delegation are initially explored, followed by a

detailing of the factors which influence their delegation decision-making. Illustrative data examples are drawn on throughout the discussion.

Perceptions and experiences

HVs were enthusiastic about 'appropriate' workforce developments to support their growing practice agenda. However, they were often dissatisfied with progress to date, with role substitution being a strong concern. For example, this HV's comments were also raised by several others:

'We would be quite happy to have skill mix on top of health visiting hours, but it's always the other way around, HV hours are always taken away'

(HV5/FG1).

Some respondents were receptive to the possibility of delegation but had experienced limited resource availability:

'I could think how it could be used, but I just don't have anyone to delegate to ... This is a great opportunity to allow me to use my skills and time more appropriately'

(HV1/FG1).

Others did not have such a bright vision of the potential benefits of expansion of the nursing team. They expressed doubts about the impact on their role:

'what will happen to my job after other people take bits of it – what will I be left with?'

(HV4/FG1).

These fears are not unfounded and indeed the issue of potential role erosion was highlighted by the DNs who reported a moving continuum in relation to their role:

'...the auxiliary is now doing a lot of what the staff nurse used to do, the staff nurse is now doing a lot of what I used to do, I'm now attending more meetings, working parties, etc.—there has been a shift in who does what'

(DN2/FG2).

When the participants were asked to describe how work-load and care management responsibilities were allocated they tended to use the term 'delegation' in referring to someone of a lower grade, for example a nursery nurse, health care assistant, or staff nurse. Respondents used the term 'sharing' when referring to distribution of work within grades. Neither DNs or HVs made any reference to delegation or sharing of work with the practice nurse or the general practitioner. This suggests that within this sample, delegation is perceived to relate to peer or subordinate work distribution.

Both DNs and HVs referred to delegating 'established' or uncomplex care. They expressed this as 'handing over the bread and butter work'. Both DNs and HVs used this term to refer to the issues they were confident to delegate. However, both groups of nurses also identified that it is difficult to disentangle individual tasks from the whole package of care they deliver.

The aim of delegating routine or assessed patient need was not always easy to achieve. Both HVs and DNs expressed concern that the evolving nature of patient need created difficulties in relation to making delegation decisions. Care needs are seen to be continuously developing, albeit at variable rates:

Just because a patient situation seems OK today doesn't mean that it will stay that way. They could develop a new problem, a complication or support could be become a problem.

(DN5/FG1)

Health visiting is about being proactive. I can't always do this if some aspects of care are covered by the nursery nurse, they are responding to a situation, something that I have assessed, I wouldn't really expect them to do anything more than respond – but if I'm not in there I can't preempt or prevent.

(HV5/FG2)

One of the complicating factors for delegation practices was that there was considerable variability in delegatee roles. For example, the aspects

of care that nursery nurses undertook could be quite different between practices. As a consequence health visiting delegation was being developed in different ways. The research focus groups therefore provided participants with a forum to explore these differences and challenge how developments could be managed:

'my nursery nurse doesn't do that – if she did I could see things being very different, I could delegate a lot more'

(HV4/FG2).

As well as variation within job title, diversity was also fostered by factors such as the type and length of nursing experience of the delegatee. As one DN said:

It depends on the nurse really doesn't it ... They could be a new D grade who is fairly inexperienced or it could be a D grade who's been working for over five years.

(DN1/FG1)

I delegate different things to different staff nurses, some are more experienced than others.

(DN2/FG1)

Another level of decision-making involved not only identifying a nursing task or aspect of care, but also locating that in a particular context and patient situation:

With some families I'll ask the nursery nurse to go in, but with others I'll do what the nursery nurse could do, because I'm still assessing other things, or I want to give the mother the opportunity to tell me about something, like a suspicion that there is domestic violence.

(HV5/FG2)

Two patients may need the same task, so to speak, but they might be very different people, I wouldn't always delegate the same thing to the staff nurse or auxiliary.

(DN2/FG2)

Patient expectation is another factor included in the decision of whether to delegate care:

They have an idea that they need a G grade because their care is so complicated, their situation is so complicated, nobody else could possibly cope.

(DN3/FG1)

Mothers expect a HV, especially if they had a child a while ago when there really was only HVs.

(HV2/FG2)

Delegation decision rationale

In terms of driving rationale, delegation decisions could be categorized into two broad bands of pragmatic, largely convenience-driven decisions, and those that were made with a specific intent to respond more appropriately to patient need. The first type of delegation practice was primarily determined by who is available, rather than who is the most appropriate worker to respond to this patient need. One nurse described a situation where she searched around to identify someone in a specific geographic radius who could carry out an aspect of patient care, rather than make a 30 mile journey herself. If this care need had arisen in the geographical area in which the bulk of the nurse's patients lived, then delegation would not have been considered. The type of care and skills needed were not central to the decision, rather geographical convenience and its economic impact in terms of travel costs and practitioner time. Another pragmatic delegation example was the redistribution of a case-load in order to even out work-load or cover absences. Sometimes necessity demanded that the work had to be delegated to someone of a lower grade due to limited availability options. An example of this would be the DN who allocated work to a staff nurse in order to provide a nursing service during the DN's day off. If the DN had been available she would have continued to provide the care. Any rationale matching skill to aspect of work was only weakly present in these types of decisions. The situation could also present whereby work was potentially inappropriately delegated from a delegatee to a HV or DN:

'Our nursery nurse is about to go on maternity leave and we know that we will

probably have to pick up the work she has been doing'

(HV3/FG1).

There were also occasions when the nurses reported that it was more expedient not to delegate care:

If I'm busy sometimes it's easier to just do it myself – by the time I locate the auxiliary – I could have done it – she could have done it as well as me and so maybe it would have been more appropriate, but the time it takes to organize prevents me from doing it.

(DN3/FG1)

The second broad band of delegation practice related to care being distributed because it was perceived that another worker could respond more effectively, economically, or in terms of knowledge base, to particular patient needs. A number of situations were identified where the respondents wished for a substitute to take over some of their work. Examples included clerical staff for administration activities, nursery nurses for play work and community psychiatric nurses for mental health issues. It was within this aspect of the discussions that a degree of conflict was evident. Consensus could not be reached by HVs about how wide a skill and knowledge base they required and consequently, when they would need to delegate or refer an aspect of care to other health care workers, such as community psychiatric nurses. This is not a surprising finding and is in keeping with the general review of health visiting and where its future direction lies.

Another type of delegation which involved skill and need matching was described by both DNs and HVs. They described cases when they and another worker, i.e. staff nurse, nursery nurse, health care assistant, provided a combination of care. In these incidences one set of skills were not deemed to be needed continuously but different sets of skills were required over a particular time period.

I would never say 'that's yours' and she [staff nurse] does it forever. We alternate, you don't just hand it over.

(DN5/FG1)

I may ask the nursery nurse to go in to deal with a problem, such as a sleep programme, but I will still be going in as well. What I'm doing is identifying an aspect of care that I could do, but as there are so many other demands on my time, the nursery nurse can do it instead – probably just as well. The thing is that two of us are then going into that house and if the mother raises something not related to the sleep programme to the nursery nurse, she has to refer it to me – that can get abit messy.

(HV2/FG2)

Delegation decision components

From the discussion so far it is apparent that there are four facets to delegation decision-making: the delegator, the delegatee, patient need and structural factors. Linked to the issue of only delegating nonvolatile or established care is the need for the delegator to have confidence in their delegation decision-making. They reported needing to feel sure that they had assessed patient needs accurately so that any delegation practice was safe. This could result in a lengthening of the assessment chain before delegation occurs, i.e. further confirming visits are made to assure the practitioner that delegation is appropriate and that their assessment of need is accurate.

Delegatee roles were significantly moulded by how well they were known by the delegator. 'This is the time of year that we've got bank staff where we have a clerk with a list of names finding a person to work for that day – we don't know them,' (DN1/FG2).

This lack of knowing resulted in a reluctance in delegation or dilution in delegation. This related back to the diversity of delegates – they are not a standard commodity – both HVs and DNs reported feeling that they had to explore and assure themselves of the competence of the delegatee before engaging in delegation. When asked to describe successful delegation practice two highly valued delegatee characteristics emerged. The delegatee had to 'know their limits' and be prepared to 'ask for help' when it was required:

You do occasionally get a person who is a bit overconfident and thinks they can do things they shouldn't.

(DN3/FG1)

She asks for help or at least reports back in detail and checks that any adjustments she has made is appropriate – she doesn't just take things for granted but feeds back to me.

(DN4/FG1)

Some HVs raised the issues of trying to ensure that delegates were not reluctant to feedback or limit their role because of an inappropriate sense of failure. A cornerstone to safe and successful delegation was establishing that it was preferable for a nursery nurse to say to a client 'I can't deal with that I will have to refer to the HV' even though by doing so the HV then has to make a visit to the family which seems to undermine the benefits of delegation, at least on a time allocation dimension.

Structural and contextual factors were another significant piece of the delegation jigsaw. The HVs and DNs reported that they were often inhibited from delegating and/or developing a consistent delegation pattern because of varying availability of delegates. Delegates may be part-time employees or 'shared' between a number of practitioners. The consequence was that the delegation you could enter into on Monday may not be available to you on Thursday. There are implications for development of other aspects of the DN/HV role and in terms of consistency for the patients receiving the service.

By virtue of the nature of community practice, the workforce are dispersed around a geographical area. This has a number of implications for delegation. One is that contacting staff can be difficult if delegation opportunities arise or a delegatee wishes to contact a delegator. This can entail leaving messages at various venues or using mobile phones to contact staff in a patient's home or even while driving between calls. These factors can be an inhibitor to delegation opportunities which require a rapid response, such as when another person is required to assist in a situation or when work-load or need changes at short notice:

I can think of lots of times when something has cropped up, maybe I would like the staff nurse or auxiliary to go into a patient late in day for an additional visit

or I'm needed to deal with something more complex and I would like to delegate something less complex to the staff nurse – by the time I track them down – phoning here, leaving messages there – it's quicker just to forget the idea and do it myself. They are mobile – that's the nature of the job.

(DN3/FG2)

The issue of geographical distance itself can reduce the likelihood of delegation taking place. For example, if the HV or DN is visiting in a particular geographical area they may consider that it is an inefficient use of resources to request that a delegatee travels perhaps 10 miles to carry out a visit in the same area.

Summary

The focus group discussions revealed a diversity of delegation practices and experiences. Decisions were driven by both pragmatic and needs assessment factors. Issues around the delegatee, the delegator, patient need and structural factors were strongly influential. Both DNs and HVs reported aiming to only delegate 'established care' but struggled to achieve this while trying to practise a holistic and process model of care provision.

Discussion

HVs and DNs were both enthusiastic to participate in the development of the community nursing workforce in order to meet increasing demand and to utilize their skills effectively. The majority of the participants in the research process had engaged in delegation activity to varying degrees of satisfaction. Delegation practices had developed in a fairly individual manner. There had been limited sharing of how this aspect of care management was handled. There is a sense that there is an assumption that HVs and DNs can engage in workforce developments necessitating delegation activity without any professional development.

As workforce diversification is a relatively recent concept in community nursing, negotiation of occupational boundaries is a key element of

delegation developments. Without suggesting that a standard format should be adopted, there appears to be a need for open debate about this issue to both assure community nurses of their role and develop their confidence in delegation. A limiting factor appears to be lack of a clear vision of the overall strategy for the community nursing workforce. This is voiced clearly by community nurses who question 'what will I do when others take part of my role away from me'. This suggests that some delegation practices are developing in an environment tinged with uncertainty. This perception may be a derivative of what staff perceive to be a substitution approach to workforce developments. This may be less apparent if a diversification approach to workforce was more obviously driving change. In view of the continuing change agenda and developments such as integrated teams, these issues require careful consideration.

Care management decisions revolve around understanding of and response to patient or client need. As Cowley *et al.* (2000) highlight, 'need is a socially constructed concept'. It is therefore possible to assume that different workers may construct patient need differently. Certainly in this research a key issue inhibiting delegation was the fact that delegates may not 'see' some of the patient needs which the delegator considered they would see. There was an element of concern expressed that it may be that there was a degree of closure in certain dimensions of patient/client need assessment once delegation had occurred. This is not exclusive to community practice as evidenced by Daykin and Clarke's (2000) discussion of the impact on the level of patient care met when delivered by health care assistants or qualified nurses. The paper includes a powerful quote from a respondent who identifies that: 'Oh they still get the care, they'll still get the bodily care ... but the intricate part of care, the clever part of care, all that might go downhill,' (p. 54).

If one recognizes that in a hospital setting the patient is still 'captive' in the ward and the nurse who could give the 'cleverer' aspects of care is still present and could potentially do so after a health care assistant intervention, then the situation seems somewhat safer in that a spectrum of patient needs may be met. The level of concern rises somewhat when this scenario is sited in the

community setting when only the delegatee may be delivering care at any one time. This sense of a potential reduction in need identification and need addressing is a key issue in delegation decision-making.

Research participants reported that they would only delegate routine care. However, the practicalities of this were extremely complex. For example, the handing over of 'routine' care may be problematic in the community setting – principally because it is not always possible to differentiate what is routine and what is not. In relation to health visiting, Cowley (1995) suggests that 'a routine visit is one that is passed'. Similarly, in their research with district nurses, McIntosh *et al.* (1999: 84) identified that 'when there was any element of risk or unpredictability in the patient's situation' the district nurses undertook the care themselves. A key factor in embracing workforce diversification in community nursing, therefore, seems to rest with the predictability of care. Indeed it may be more than predictability, but the lack of opportunity to supervise responses to risk and uncertainty (Carr, 1999).

Lack of satisfaction with the level of supervision achievable in the community setting and the amount of time this activity required was a disincentive to delegation practices. The Oxford Dictionary (1941) defines delegate as 'send as representative'. This could be interpreted as sending someone on your behalf, but not instead of you. There are complex issues at play here which inhibit delegation practice. At the core are issues of responsibility and how this is managed. Sibbald (2000) reports that general practitioners are usually not reluctant to delegate aspects of their work to practice nurses. There may be a number of issues involved here, but one factor worthy of consideration is the context in which the GP delegates to the practice nurse. The delegation usually occurs within a building whereby both the delegator and delegatee are potentially physically in the same environment. There is, of course, a similar scenario in the hospital ward environment. The lack of a physical infrastructure poses additional delegation complexities for the community nurse. The delegation practices which nurses use in hospital do not therefore readily transfer to the community setting.

Limitations on the research and future work required

The research was exploratory and was successful in exposing many issues integral to delegation within the community nursing team. The data were collected from one primary care trust in the north of England. Although there was some diversity in delegation practices, it must be acknowledged that historically the nurses had developed their delegation practices under the same leadership and management system. Comparison with another area where delegation had been approached differently would provide an additional perspective.

The research sample was restricted to DNs and HVs. In future research it would be appropriate to extend the sample to include staff nurses, health care assistants, nursery nurses and recipients of care to enhance understanding from multiple perspectives. Further research that compared experiences of actual delegation practices from both professional and client perspective would add another more specific dimension to this generally reflective discussion on the subject of delegation. There is also great potential to develop outcome research to compare the impact of different skill/health care provider input to the care process.

Conclusions

The research reported in this paper has illuminated how these groups of community nurses interpret the term 'delegation'. It has also facilitated the exposure of their experiences of operationalizing the concept in practice. The community nurses were generally receptive to the idea of development of the workforce, but uncertain as to the most appropriate option, often fearing a purely substitution approach. All the DNs and most of the HVs had delegated aspects of care management to others. However, there were degrees of dissatisfaction with this process. This appeared to be largely driven by the fact that the current delegation model was task oriented and this was in conflict with a philosophy of holistic and process care which the nurses wished to provide.

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The delegation decisions reported in the research revealed a complex process which had at least four components: delegator, delegatee, patient and infrastructure issues. Some care was delegated in order to meet health care need more appropriately.

Delegation also occurred due to pragmatic constraints where patient need was not the only, or even the prime driver. A key requirement for effective delegation is a consistent workforce framework of delegates. In order to move away from the tendency to analyse delegatee appropriateness on an individual basis, there needs to be some standardization and perhaps development of the skills and skill combinations held by delegates.

Finally, this research suggests that it is important to recognize the community context of practice increases the complexity of delegation decision-making. It is different to delegation activity in a hospital or health centre setting where supervision and interprofessional communication is immediately available. Application of delegation skills learned in the hospital context are therefore not directly transferable to the community context. This is perhaps an education need which requires greater attention.

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